University of Best Practices Meeting, San Diego

Meeting Notes

April 4, 2011 12:00pm-2:30pm

Please see accompanying slide presentations and materials distributed at the meeting.

Dr. Penso – Introductions and Review of RCI goals

- For those of us striving to form an ACO, it's important to keep these goals in mind (see slide – RCI/HEDIS goals)
- We're here to learn from each other, share best practices, and move towards common understanding

Jan Hirsch – UCSD School of Pharmacy Professor – Pharmacist on the Care Team UCSD Experience

- $7.98 ROI for MTM Services – the "wow" slide - we're going to get back to this figure and review the evidence for it
- Three studies – please see the list of references distributed
- Chisholm-Burns et al. 2010 – This is the most recent review. They performed a systematic review of the literature. Jan pointed out the search strategy and distillation from the larger 298 articles that met the quality and evidence requirements.
    - The authors observed studies from several different settings, broad sampling of types of payers and institutions, etc.
    - Therapeutic outcomes - 80s% favorable outcome in several types of outcomes.
    - Safety outcomes – adverse drug events – between 60 and 80s% on outcomes. 28 studies looked at this specifically
    - Summary – positive evidence for therapeutic, safety and humanistic outcomes.
- Second review – same authors (Chisholm-Burns et al. Oct. 2010) looked at 126 articles that looked at economic outcomes specifically. Same mix of settings, payers, etc. Many different types of costs, hospitalizations, providers, etc. Several indirect costs considered as well.
    - Most economic reviews were flawed 20 = 16% showed favorable outcomes
    - $8 ROI drawn from this article.
- Perez et al. 2008 study, review from 2001-2005 – looked at economic outcomes. 15 had a benefit cost ratio
    - Many different settings, interventions,
    - Some hospitals, some outpatients

    - Studies vary, each program is very different
- Question from Dr. Yphantides : Was there an attempt to tier the MTM services into different types or kinds of services provided? Answer – Jan, no not in these reviews.
- Question from Dr. Fremont: Follow up to Dr. Yphantides' question. In perusing the studies, there are several different types and ancillary services also included. Are there any standouts in terms of kinds of settings that seemed to be most effective? Answer – Jan, there was so much variation especially between those that were held in inpatient versus outpatient settings, it is hard to highlight any in particular.
- Comment from Debbie Ling Grant: These are the most recent reviews of MTM services, especially the economic reviews. But there are some important limitations in these reviews. Most recognize the methodological shortcomings, but then still report the ROI from the studies with the flaws. The article that reports the $8 is an average from 15 studies in several different countries and the figure (from 11/15 articles) is calculated by the reviewers not the study authors with unknown methodology. The recent review that highlight the 20 articles with favorable economic results does not point out that those 20 articles are not necessarily the ones deemed as using "good" methodology.
- UCSD experience – We're looking at a different model here. Internal medicine group at UCSD – PharmD medical collaborative versus usual care. (see slide of study design)
    - 42% had a drug therapy problem identified
    - 35% had a change noted at initial visit
    - We have a good representative sample of uncontrolled HTN
    - Using many different prescription medications
    - We overlooked an important study objective – logistics – new provider, scheduling, EMR, coding, space, etc.
    - Potential payment/reimbursement – CPT codes
    - UCSD clinical pharmacist models – some are in groups some are at medical center
    - Our future directions –evaluation - looking for different models, those that are sustainable, transferable, and scalable.

Rebecca Cupp - Ralphs Pharmacy – Review of what they are doing in Communities

- Here we focusing on patients with chronic conditions - they tend to fill more prescriptions
- Costs per person can get above 57% when you get to people who fill 5+ medications
- The Healthcare Team of the Future should include "Clinical pharmacists" – with the ACO discussion we are all in we need to think about the interactions between all of these folks

- Integrating pharmacists into ACOs – decrease adverse drug reactions, fewer medication errors, improve patient compliance with drug regimens, and higher overall quality of life scores
- 3 basic models – academic clinical pharmacist, medical group in-house pharmacist, and community pharmacist – we focus on the community pharmacist today
- What is the standard for the MTM services being provided? The pharmacy quality alliance (PQA) is looking at this issue. There are also other orgs that are also looking at this. Pharmacists must complete a certificate program in their specific area.
- Initial visit- most time consuming – look at labs, meds, and perform patient education. We prefer to do this face-to-face. Look at smaller and independent group practices
- Follow-up visits 4-6 over a year - complexity of regimen, adherence
- Documentation – this is a challenge. There are some web based platforms now that are promising.
- Payment and ROI – Calculations indicate a return per dollar of MTM of over $10 in their own internal ROI work.
- Benefits – accessibility, familiar, no "white coat" syndrome
- Kroger company background – company is committed to providing patients with a healthy lifestyle – history of past services (see slide)
- Coming soon programs 2010 diabetes disease state program – extension of diabetes program – weight management
- Cincinnati Program – modeled after the Asheville project. They are not necessarily looking to it as a study design. They are attempting to have a stronger design - but not explained exactly how the program is stronger.
    - Over 800 patients enrolled – they are about to publish these results in the next few months so she cannot share everything. Clinical outcomes very well measured and medication compliance
    - Diabetes coaching – increases in reaching their goals
    - Where copays were completely waived they increased compliance by 58.2% in a 6 month timeframe. This is why she feels it is important for one part of these programs to include a complete waiver of patient copayment
    - When they were reduced by 50% there was less increased compliance – see slide
    - Employer financial impact – Baseline HbA1c – see slide
    - Over a 9-month period there has been significant improvement amongst the 29 in the diabetes coaching program. There was a slight uptick due to one patient having an autoimmune disease on top of their diabetes.
- Question Dr. Fremont asks Rebecca to explain the setting - private or semi-private areas in the store pharmacy. Answer: patients are seen in private or semi-private counseling areas in the store pharmacy, not at the counter.

- Question Dr. Dudl asks to clarify entry criteria and procedures for the program. Answer: They are identified for us and then Kroger contacts them and asks if they want to be part of the program. We take care of scheduling the patient to come in. If they are referred for MTM from their health plan, then there isn't really that connection so we don't know exactly who they are.
- Each patient has an outline of the process and procedures and goes through an informed consent process. We help them to set goals – and make sure that patient understands what they have agreed to whether it is follow-up labs, HbA1c testing, etc.
- Question Dr. Green – Is program offered to employees? We send all the documentation to the prescriber. If you are recommending a medication change – how would you do that? Answer: Right now, these procedures are completed by fax or phone.
- Question Dr. Bayne – if there are 15+ doctors for patients where there are many multiple medications - how do I negotiate that? Which doctor do I communicate with? Answer: Yes, all the doctors ideally should be notified. Multiple primary care providers for these high cost patients. The protocol is to communicate everything we do to all patients.
- Comment from Liz Helms - she mentions the PCMH model and how the emphasis is having a central coordinating person/doctor to coordinate these communications.
- Comment from Dr. Ganiats – Maybe the patient and pharmacist can help each other identify the primary doctor. He posits what about when one has a great drop in HbA1c – what about side effects – for instance an increased incidence of hypoglycemia that results from such a drop? Answer from Linh Lee: Actually, she says no there hasn't been an increase in adverse events due to the drop. Dr. Ganiats clarifies that he means hypoglycemia. Rebecca mentions that yes they also track blood glucose. Grace Kuo offers that with the DCCT trial – with metformin – there shouldn't be too much hypoglycemia. She asks about the types of patients included in the trial. Rebecca clarifies that they are working adults.
- CPT codes are still an issue when we are not identified as a provider
- Rebecca holds up most recent issue of "Pharmacy Today" - key article talking about MTM – they speak to other pharmacists about MTM
- Barriers – communicating to healthcare team
- Grants outstanding – pilot programs – NACDS –RFP measure medication non-adherence (PMN) – the objective is to measure PMN and develop a PMN intervention. Complex design and model
- Medication reconciliation – how do we get patients safely back into their communities – collaborate with med recommendation system or provide themselves
- Pending San Diego Demonstration Project – union and Health care insurer project

Dr. Penso – introduces the breakout session groups. Breakout group report back results below.

- Some possible breakout questions:
    - What model(s) do you think apply to your practice?
    - What would the benefits be from working with a pharmacist?
    - How can we overcome barriers to having a pharmacist on the care team?
- Group 1: Pharmacists on care team does have a role. Should they be internal versus external?
    - Some doctors will be for it but others will feel threatened. Some doctors will want a lot of hands on care others not so much
    - Standard follow-up on therapy – reminders – standardized.
- Group 2: Several community healthcare setting people in this group. They looked at a model that might work in the CHC. Team-based care seems to work. Embedded pharmacist – cultural and language issues are a consideration. Payment issues. My patients identify more with the RN CDE. They may listen to her more than to me. The benefits of the pharmacists – know all the drugs, they can help figure out what some unknown meds are, physician time is strapped and precious. Barriers – payment – if we are getting $8 ROI someone else is reaping that benefit. It's not accruing to us. Even if we could bill for it, does it count against the 7 visits.
- Group 3: (Debbie Ling was the scribe and report out person for this group so the notes are longer and more detailed)
    - Dr. Bayne – I'm back to the issue of multiple physicians – who's the primary care physician.
    - Health plan pays for six visits a year – for those that need additional visits – they can go up to 8 visits. For Ralphs Consolidated Health Plan members, they can see PCP or specialists. They encourage the pharmacists to contact the PCP to introduce them and get them
    - Physicians in groups need to understand what they are getting into and then make the effort to close the loop back to the pharmacist. The responses that Ralphs has gotten has been positive. They have patients that go to multiple pharmacies and multiple physicians. Several technicalities, it depends on things like where the patient lives.
    - Dr. Green brought up the issue of patients asking for discontinued or old meds. Linh mentions that they have a flag that comes up DUR – drug utilization review.
    - Paying for meds – if there's no claim generated we won't get that. So, if they pay cash, it might not show up in the system. Non duplicate claims won't show up as readily. Absence of a claim – if only 50% of the meds are picked up in the claim,

we might not know for some time. Fill non-compliance – to be that person to manage that you have to be a central person to catch that. Linh Lee says they are working on that- getting that kind of information back to the PCP.

- Dr. Green mentions - What about nuisance interaction versus strong interactions? To be able to control these more nuanced issues is a big coordination issue. Who is paying for these kinds of coordination – who will fund these types of services? Robert mentions that for their current ACO they have built in some funding for the people who have to make that coordination work. Build it specifically in the budget.
- Grace Kuo mentions a local PBM can be given a password, the physician can check all the meds a patient is on and whether they are filling them. But Dr. Green feels that from a practical standpoint the doctor won't have the time or impetus to really be responsible for that reconciliation.
- MTM seems to save money with the most high cost patients, but it is total guesswork, the patient themselves don't know what meds they are on, patient communication is poor, family communication is poor. No way to really know what is going on especially with this population with so many comorbidities and mental incapacities especially with advanced disease. The caregivers may not be the best people to negotiate these communications either.
- Do patients bring all their meds in a bag? Linh says oh yes, we ask them to. As part of the CMR, what meds from any other patients from any other sources. Over the counter, herbal supplements, etc. Are they compliant with this information? A big part of the first visit which is usually 90 mins is on patient education on the disease. Do you know what diabetes is? Do you know why you are taking this med? Reinforcement on adherence.
- What if pharmacists were to go out to the patients' house rather than the physician? ACO is currently trying this model. New profit incentive to include the pharmacist. Techs do call the patient and get them to come in – scheduling etc. But they can't make nuanced decisions. Pharmacists cannot prescribe but under protocol they can recommend.

- Group 4: Patient P4P. We talked about different expectations of different stakeholders – MTM for pharmacist, patients, and physicians. But what about the groups that haven't "drank the Kool-Aid" heard the gospel etc?
- Dr. Dudl speaks a bit about sensitivity to practitioners – for adherence versus getting on new meds it's a different story.
- Dr. Fremont wants to underline the consumer experience. It's really important to keep the issues from a consumer perspective in mind.
- Dr. Penso thanks everyone and adjourns the meeting.

Notes prepared by Debbie Ling Grant, Comparative Effectiveness and Outcomes Improvement Center